**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministére de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

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**Public Copy/Copie du public**

| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Sep 20, 21, 22, 23, 2011; Feb 21, 22, 2012 | 2011_104196_0004 | Critical Incident |

**Licensee/Titulaire de permis**

THE CORPORATION OF THE CITY OF THUNDER BAY
c/o Dawson Court, 523 Algoma Street North, THUNDER BAY, ON, P7A-5C2

**Long-Term Care Home/Foyer de soins de longue durée**

PIONEER RIDGE
750 TUNGSTEN STREET, THUNDER BAY, ON, P7B-6R1

**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

LAUREN TENHUNEN (196)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW)**

**During the course of the inspection, the inspector(s) conducted a tour of the home, observed the provision of care and services to residents of the home, reviewed the resident's health care records, reviewed the critical incident report submitted to the Ministry of Health and Long-Term Care (MOHLTC), reviewed the home's policies and procedures for the use of resident care equipment and transferring, reviewed the manufacturer's brochure for equipment.**

**The following Inspection Protocols were used during this inspection:**

**Personal Support Services**

**Safe and Secure Home**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

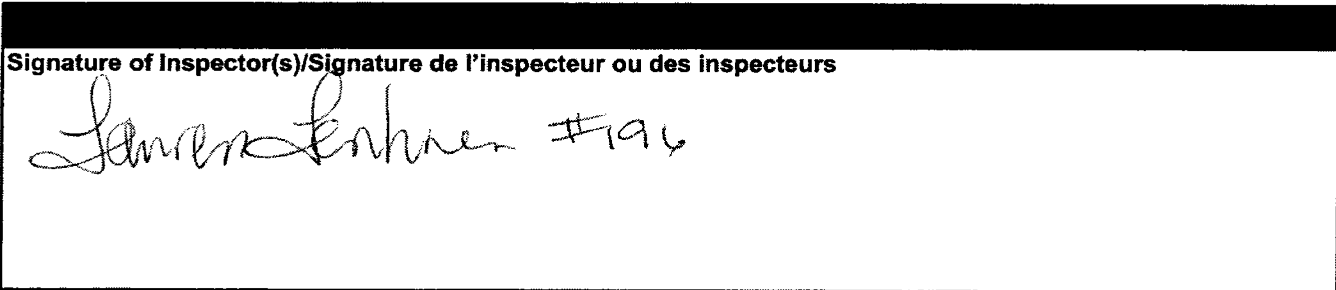
| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>WAO – Ordres : travaux et activités |
| Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)<br><br>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. | Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. A critical incident report was submitted in August 2011 to the Ministry of Health and Long-Term Care (MOHLTC) for an injury that required transfer to hospital for a resident of the home. The critical incident report stated that during a transfer of a resident, a piece of equipment was not secure and let go and caused injury to a resident. The nursing notes from the incident date identified that a piece of equipment released and struck the resident causing injury. A review of the manufacturer's brochure was conducted which showed the equipment that had been used. A review of policy # NS POL 127 titled "Minimal Lift (Policy) Procedures" was conducted and stated that staff are to "conduct mini assessment of equipment, resident and environment prior to each procedure/use". The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [O. Reg. 79/10, s. 36.]

**Issued on this 23rd day of February, 2012**



**Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs**